2002

Annual Report

to the Governor and the General Assembly

State of Connecticut

Office of Health Care Access

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Report To The Governor & General Assembly

January 1 - December 31, 2002

Ensuring that citizens of Connecticut have access to quality health care is the primary mission of the Office of Health Care Access (OHCA). In 2002, the agency continued to fulfill its mission by designing and directing health care system development, advising Executive and Legislative Branch policy makers on health care issues, and informing the public and industry of statewide and national trends.

Mary M. Heffernan was named Commissioner of the Office of Health Care Access by Governor John G. Rowland in August 2002.

OHCA oversees Connecticut's health care delivery system to ensure that access to affordable, quality health care is available to citizens of the state. The agency's major functions — health care data collection, analysis and reporting, hospital finance review and reporting, and administration of the Certificate of Need program — complement each other and provide much needed insight into the state's health care delivery system.

The relationship of cost to quality and access forms the cornerstone of OHCA's activities. The Certificate of Need program affects cost, quality and access by assuring that an appropriate amount of services are available, while the potential for the damaging effects of excessive saturation and duplication are minimized. The Uncompensated Care program uses hospital data certified by OHCA's hospital and health care reporting requirements to calculate Disproportionate Share payments to hospitals. OHCA's analyses of facility utilization allow the agency to forecast needs and health care system trends. Finally, as the State is the largest purchaser of health care in Connecticut, it is particularly imperative that OHCA continue its objective and accurate analysis and reporting of health system developments, in order to allow the State to fully leverage its purchasing power in a coordinated manner.

Oversight & Forecasting

With the ongoing evolution in health care delivery, driven in large force by improvements in treatment and simultaneous cost constraints placed by government and commercial payers, Connecticut's 31 acute care general hospitals have weathered significant turbulence in recent years.

While Connecticut's acute care hospitals vary significantly in size and the populations they serve, they face many of the same operating challenges. The familiar forces placing stress on Connecticut hospitals and the health care delivery system as a whole include rising labor costs and insurance premiums, lower reimbursement rates, reduced investment returns, costs associated with new technology, and aging population demographics. Most hospitals are also facing additional pension fund expense caused by poor investment performance that will require increased pension fund contributions.

These factors, along with a weak economy, have created an extremely challenging environment for Connecticut's hospitals. This was documented in OHCA's June 2002 report, the ***Sixth Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals***, mandated in Section 19a-670 of the Connecticut General Statutes. The report provides quantitative and qualitative information as well as analytical insights on health policy issues that are important to the State of Connecticut and its citizens.

Because health care spending consumes a large and steadily growing portion of the state budget, and access to care may be negatively affected by a struggling economy, monitoring the financial performance of Connecticut's hospitals is critically important to state leaders and policy makers. In order for the agency to address this information need, the state's 31 acute care hospitals are required by law to file their financial and statistical results with OHCA each year.

OHCA's 2002 Financial Stability Report detailed hospital fiscal results for Fiscal Year 2000, and summarized the facilities' efforts, successes and challenges during that extremely difficult year. Nine of 31 Connecticut hospitals were operating at a loss on total bottom line; four were operating at a loss on patient care but achieving minor positive margins on non-operating income. Eighteen were achieving a positive margin on both patient care and total bottom line. While OHCA reported that no hospital was in imminent danger of closing, it encouraged hospital leaders and state policy makers to remain vigilant in refining Medicare and Medicaid payment policy, negotiating managed care contracts that exceed cost inflation, and identifying strategies to curb growing costs associated with workforce shortages, pharmaceuticals and new technology.

Assessing Hospital Uncompensated Care

Patients at Connecticut's hospitals are treated regardless of their ability to pay, with the exception of non-emergent care such as elective and cosmetic surgery. The Disproportionate Share Hospital (DSH) Program, launched in 1991, provides funds to Connecticut's acute care hospitals based upon each hospital's uncompensated and undercompensated care as a percentage of the statewide total. Using the financial data filed annually by the hospitals, OHCA performs the calculations for the DSH program so these needed dollars can be made available. In SFY 2002, OHCA's calculations resulted in $85 million being disbursed in DSH-related payments.

Research, Analysis & Policy Development

OHCA's data analysis is not limited to hospital finance. In order to best inform policy makers, the health care industry and the general public about the changing face of the state's health care system, the agency also gathers, analyzes, interprets, and communicates extensive health care information, including hospital utilization data, graduate medical education costs, claims data, and information on the uninsured.

The 2001 Household Survey results showed that an estimated 185,200 people were uninsured at the time of the survey, and approximately 124,900 Connecticut residents were uninsured for the entire prior twelve months.

Understanding the Scope of the Uninsured

In these times of rising health care costs and economic uncertainty, legislators, policy makers, program administrators, members of the media and the general public often confront the issue of those persons who are uninsured and thus at risk of being restricted in their access to health care. Connecticut gained a better sense of the level and characteristics of its uninsured population in 2002, as OHCA produced the results of a major household survey.

In 2001, supported by a State Planning Grant awarded earlier that year by the U.S. Department of Health and Human Services' Health Research and Services Administration (HRSA), the Office of Health Care Access contracted with the University of Connecticut Center for Research and Analysis (CSRA) for a study of the uninsured in the state. Nearly 4,000 households participated in telephone interviews conducted by CSRA on behalf of OHCA. Survey results identified the numbers and characteristics of the state's uninsured citizens.

Survey results showed an estimated 185,200 people were uninsured at the time of the survey, and 278,500 had been uninsured at some point during the preceding 12 months.

In addition, OHCA found that 3.8% of respondents, approximately 124,900 residents, were uninsured for the entire prior twelve months (Figure 1).

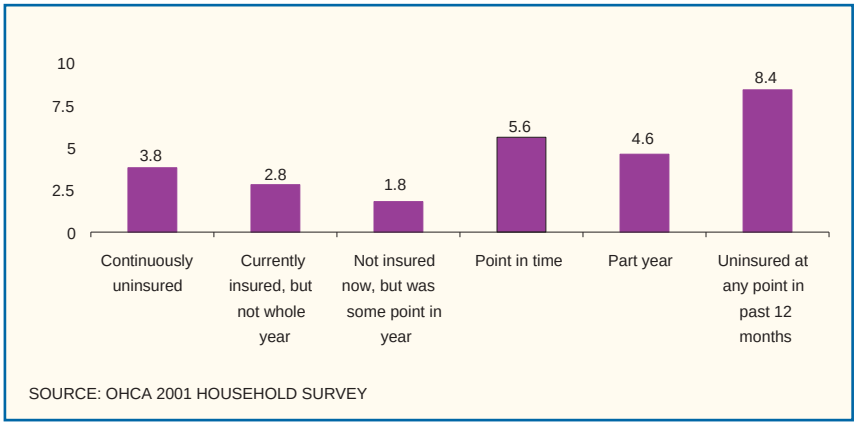

Figure 1: Rates of Connecticut's Uninsured by Duration

Singles, young adults, people without a college degree and minorities had higher than average rates of uninsured. Family income had the strongest effect on insurance status, as the lack of coverage was much more extensive among low-income families.

Ninety-three percent of Connecticut's working-age adults were insured and most had established a regular source of primary care at a physician's office. The overwhelming majority of the estimated 150,800 uninsured working adults were employed in firms with 50 or fewer employees. These firms were less likely to offer insurance coverage than larger ones, and in those that did offer coverage, employee premiums were often more than the uninsured worker could afford to pay.

Among uninsured working-age adults, one in four did not have a regular source of care, one in five did not get necessary care for an illness, and one in ten did not seek treatment for a medical emergency. Just over half of this group received their primary care at a physician's office, while one in ten relied upon hospital emergency departments.

The number of Connecticut's uninsured is surely increasing now, as the unemployment rate rises in a struggling economy. State and federal agencies are focusing on how to provide the uninsured with access to coverage at a reasonable cost, as well as help those who already have coverage to maintain it in the face of rising premiums.

In June, 2002, OHCA began publishing a series of issue briefs examining survey findings, including the demographics of the uninsured, and the relationship between insurance coverage and access to health care services. Future briefs will focus on the working uninsured, children's coverage and the intermittently insured.

Developing Options for the Uninsured

The Office of Health Care Access sought and received an extension of its HRSA grant to September, 2003, during which time it will refine options and models and conduct additional program design activities needed to implement a health insurance subsidy initiative in Connecticut and prepare a waiver application for a HIFA demonstration initiative.

OHCA has also recommended federal action to support state efforts to provide health insurance for the uninsured by providing states with flexibility to tailor programs to meet the needs of various populations. The agency is using and sharing its Household Survey findings, along with other information gathered through the HRSA State Planning Grant, in an effort to design proposals for providing uninsured citizens with access to health care by creating new coverage expansion options.

Developing Innovative Purchasing Models

From 1999 to 2002, the Office of Health Care Access, through a three-year grant from the Robert Wood Johnson Foundation, led the **ACHIEVE** initiative to identify and pursue opportunities for the State to leverage its purchasing power when procuring health care benefits for State employees and retirees, HUSKY members, and individuals receiving fee-for-service Medicaid benefits.

ACHIEVE initially focused on ways to enhance State purchasing of medical benefits, but dental benefits soon emerged as the focal point, primarily due to the degree of common interest in this aspect of health care.

At project's end, a key accomplishment was the development of a joint dental procurement effort among two major state purchasing agencies. When implemented, this collaboration will leverage the attractiveness of the State employee dental contracts in order to improve the level of access and service provided to HUSKY and Medicaid participants — without compromising any existing benefit programs.

A key accomplishment of ACHIEVE was the development of a joint dental procurement effort among two major state purchasing agencies.

Representatives of the Department of Social Services, the Office of the State Comptroller and the Office of Policy and Management are joining OHCA to collectively pursue the joint purchase of dental benefits.

A primary objective of ACHIEVE was to encourage state agencies to identify common health care purchasing needs that could be better met when addressed collaboratively rather than individually.

ACHIEVE met this objective, and established awareness among the participating agencies of potential areas of collaboration that will benefit the constituents they serve. Project products include:

- purchasing specifications that document requirements common to the participating agencies;
- identified data and data sources to support reporting and analysis of program costs/performance as well as data deficiencies;
- a results management database that uses monthly financial and quarterly performance reporting for covered populations; and
- a modeling tool that projects the State's health care costs and supports decision-making concerning the use of insured or self-insured funding arrangements.

Pursuing Cardiac Care Improvements through the Connecticut Cardiovascular Consortium

For several years, the Office of Health Care Access has assumed a leadership role in the creation of the Connecticut Cardiovascular Consortium (C3), a statewide initiative among Connecticut hospitals and OHCA. Its purpose is to provide a collaborative research infrastructure to advance quality and outcomes for Connecticut residents with cardiovascular disease. OHCA's role was to facilitate the development of the group and formulate its first clinical research project.

In July 2002, the Consortium submitted a grant application to the Donaghue Foundation and Connecticut Health Foundation, requesting funds for a statewide observational study on the treatment of ST segment elevation acute myocardial infarction in Connecticut. Throughout the year, OHCA worked proactively with consortium leadership to ensure participation in the study by all 30 non-profit acute care hospitals. The grant application is still under review by the funding entities.

If grant monies are made available, the resulting research could improve cardiac care outcomes and contribute to a larger body of knowledge for hospitals and the state.

Development of the consortium has strengthened relationships among cardiologists in the state, in particular those physicians who participated on the consortium's Operations and Steering Committees. At this time, the consortium leadership is working to establish the Connecticut Cardiovascular Consortium as a legal entity, which would provide the necessary infrastructure for a productive and sustainable organization.

Assessing Graduate Medical Education

As mandated by Public Act No. 99-172, OHCA conducts an annual study on graduate medical education (GME) and its impact on Connecticut hospitals. In December, the agency released its third ***Annual Report on Graduate Medical Education*** based on 2000 data, the most recent available from the national Centers for Medicare and Medicaid Services.

The analysis shows that seventeen Connecticut hospitals received approximately 154 million graduate medical education dollars from Medicare and Medicaid in 2000. The report concluded that the amount of revenue received by the state's teaching hospitals from GME payments is relatively small, has declined over the past several years and is expected to continue declining in the future due to federal payment policy changes.

Although GME programs may have little effect on the sufficiency of the physician workforce in Connecticut in terms of the actual number of physicians, their effect may be more appropriately viewed as one of establishing and maintaining diverse clinical skills needed for the treatment of the state's residents.

Certificate of Need Activity

OHCA's Certificate of Need (CON) program helps limit excess costs to the health care system by preventing unnecessary duplication of health care technology, services and programs. The CON process also provides an opportunity for consumer, provider and payer input, and encourages applicants to consider collaborative efforts and multiple perspectives in developing an effective, responsive health care system.

In 2002, OHCA conducted 68 CON reviews and 105 CON determinations. Many CON reviews were for equipment acquisition -- both clinical and non-clinical -- and physical plant renovations and expansion. Thirty-one reviews were for the acquisition of imaging equipment or linear accelerators, and 18 were for equipment upgrades or replacements. In addition, OHCA processed 11 CON determinations for imaging equipment acquisitions that had a capital expenditure of less than $400,000.

Several major facility renovations, including those at MidState Medical Center, Connecticut Children's Medical Center, Greenwich Hospital and Rockville General Hospital, were granted CON approval in 2002. The MidState, Children's Medical Center and Greenwich Hospital projects include bed additions due to increasing utilization at these hospitals.

Figure 2 illustrates the recent trend toward outpatient service development, as CON requests for new services in 2002 were primarily for ambulatory services, including ambulatory surgery facilities, endoscopy services, lithotripsy, and wound care.

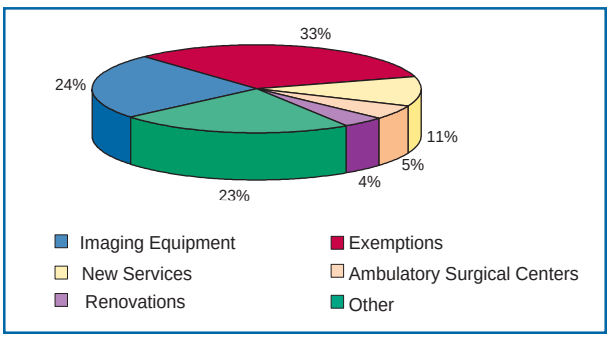

Figure 2: 2002 Certificates of Need and CON Determinations

More than half of all CON determinations were for new services provided by non-profit agencies that could be exempted from the CON process. Most of these exempted determinations involved behavioral health or primary care services.

Addressing Compliance Issues

OHCA's Compliance activity ensures that entities that have previously received an approved Certificate of Need are developing and maintaining service delivery as specified by OHCA in its CON approval. The Compliance office also considers facilities' requests for modifications to their existing Certificates of Need, and determines and recommends to the Commissioner the imposition of any civil penalties on entities that are not complying with the agency's fiscal or CON reporting requirements.

In 2002, OHCA initiated and acted upon 14 CON Determinations as a result of Compliance inquiries; five of these were determined to require CON authorization. The agency also approved 27 requests to modify previous CON authorizations, and issued 53 letters to CON holders who were not in compliance with the reporting requirements set forth in their earlier authorizations.

In response to concerns of legislators and the public, in August OHCA and the Office of the Attorney General jointly issued a request for information from all Connecticut acute care hospitals to determine which, if any, of their clinical and non-clinical services had been *outsourced*, whereby the hospital had entered into a contractual arrangement with an unrelated organization or company for the ownership, control, operation or management of any clinical or non-clinical function or service that would otherwise be performed by the hospital (or an affiliated entity).

As a result of this inquiry, OHCA is investigating outsourcing contracts related to Emergency Department services at two Connecticut hospitals.

Adapting & Responding to Changing Conditions

The changing face of health care requires OHCA to be vigilant in crafting a flexible and responsive regulatory environment that allows hospitals to take full advantage of federal programs, control expenses, and create new models for health care delivery, while ensuring that systematic safeguards remain in place.

In 2002, OHCA gained approval for two key pieces of legislation that demonstrate progress in this area. Public Act 02-101, ***An Act Concerning Hospital Finance and Data Reporting,*** eliminated or reduced many outmoded hospital budget filing requirements related to hospital rate-setting, a practice that had been statutorily repealed in 1994. The new law also eliminated the filing by hospitals of their commercial payer discount agreements; this information will now be kept on file in each hospital's business office. In addition, the law authorized OHCA to collect audited financial statements from Connecticut's specialty hospitals to allow the agency to monitor their financial performance.

OHCA was also successful in gaining passage of Public Act 02-6, ***An Act Concerning Late or Missing Data and the Office of Health Care Access***. Conceived as a means of maintaining the quality of OHCA's hospital budget system data, this new law allows OHCA to refuse to consider a Certificate of Need application from a facility that is not current in its mandatory financial reporting to the agency.

In addition, OHCA paid considerable attention and effort in 2002 to revise its regulations on the collection of financial and discharge data from health care facilities. The updated regulations will be put before the Legislature's Regulations Review Committee in early 2003.

Because hospital-filed data is such a critical element in OHCA's daily functions and meeting its overall mission, the agency continues to closely monitor its filing requirements with an eye toward streamlining or eliminating any filings that become irrelevant or outdated. In addition, the agency is vigilant in assessing the information needs of its constituents and adapting to meet those needs.

In 2002, OHCA performed a comprehensive review and revision of its application forms for Letters of Intent (LOI) and Certificates of Need -- the second such adjustment in three years. The new forms, which are posted on the OHCA website and are ADA-compliant, significantly streamline the amount of information required, yet yield highly relevant information for OHCA's review and analysis.

OHCA's Certificate of Need decisions and its CON/LOI status reports provide valuable information to health care industry leaders as they plan improvements to their health care delivery systems. Since early 2002 and going forward, OHCA posts all CON decisions and monthly status reports on pending applications to its website, where they are conveniently available to anyone interested in reviewing and/or downloading them. This website modification has earned tremendous praise from providers, attorneys and others interested in monitoring OHCA's rulings.

2002 Summary

OHCA continued its record of success during 2002 in working to ensure a quality health care system for the citizens of Connecticut. The agency's research, analysis, regulatory and reporting functions continue to focus on assisting Connecticut policy makers and industry leaders to monitor the health care delivery system, identify areas of potential need, formulate appropriate solutions, and better coordinate state policy and actions to control cost and improve health care quality in the state.

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